PATIENT INFORMATION

Patient's Full Name ____
Last First Middle Maiden

Age__________ Date of Birth______________ Sex__________________ SS#______________________

Marital Status: Single_____ Married_____ Widowed_____ Divorced________ Preferred Language ______________

Address____

City__________________________ State______________________ Zip______________________

Home Phone____________________ Work Phone__________________ Cell Phone____________________

E-mail Address__________________________ Pharmacy & Location-**required**__________________
(If you do not wish to receive email from Northeast Georgia ENT and Garlich Facial Plastics, DO NOT give email address)

Employer:____ Occupation:__________________

Preferred Contact (if other than patient)____________________________ Contact Phone________________

Preferred Method of Communication (Choose One): Mail **Patient Portal** Home Phone Cell Phone Text Email

RACE & ETHNICITY (Per the Federal Government we are asked to gather the following information)

Race: American Indian/Alaskan Asian Black/African American Hawaiian/Pacific Islander White Other Declined

Ethnicity: Not Hispanic or Latino Hispanic or Latino Declined

SPOUSE OR PARENT INFORMATION

Name____

Date of Birth:________________ SS#__________________________ Work Phone: ____________________

Employer and Address:____

EMERGENCY NOTIFICATION

Name____ Relationship:__________________

Home Phone____________________ Work Phone__________________ Cell Phone____________________

PRIMARY CARE PHYSICIAN (medical doctor)

Family Physician:____ Office Phone:__________________

REFERRING PHYSICIAN (the doctor who sent you to see us not the facility where you were seen)

Referring Physician:______________________________________ Office Phone:__________________

AUTHORIZATION FOR TREATMENT

I hereby consent to treatment by the health care providers at Northeast Georgia Otolaryngology dba Northeast Georgia ENT (NeGa ENT), such treatments may include x-rays, hearing tests and other procedures as deemed necessary. I also hereby consent to the retrieval of my medication history electronically.

____
Signature of Patient, Parent or Guardian Relationship to Patient Date

____
Print Full Name

PLEASE COMPLETE BACK OF FORM

HIPAA ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the NeGa ENT Notice of Privacy Practices. I understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy.

I authorize NeGa ENT to release and/or obtain my records to/from other physicians for the purpose of continuity of care.

Signature of Patient, Parent or Guardian　　Relationship to Patient　　Date

I authorize NeGa ENT to release my information, including diagnosis, records and claims information to the following individual(s):

Name　　Relationship to Patient

Name　　Relationship to Patient

Signature of Patient, Parent or Guardian　　Relationship to Patient　　Date

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Financial Policy: Payment is expected at the time of service. We accept cash, check or credit card. If we are contracted with your insurance, we ask that you pay any co-payments, co-insurance and deductibles that have not been satisfied. Co-payments must be paid prior to seeing the doctor. ***If the patient is a minor, financial responsibilities lie with the parent/guardian bringing the child***

Your insurance policy is a contract between you and/or your employer and your insurance company. ***Depending on your insurance plan, some office procedures (for example, hearing tests and endoscopies) are either not covered or subject to deductibles and co-insurance in addition to your co-payment.*** It is your responsibility to know your insurance plan benefits.

No Show Policy: If an appointment is not cancelled at least 24 hours in advance you will be charged a **$50.00** fee.

Self Pay Financial Policy: For services rendered in the office, a minimum payment of **$175.00** is required prior to seeing the doctor and the remaining balance is due at check out unless other payment arrangements are made in advance. For elective surgical services, payment in full is required a minimum of two weeks prior to the surgery date unless other arrangements are made in advance.

Assignment of Benefits: I authorize the release of any information necessary to process claims and direct payment to myself or the doctor who accept assignment.

Signature of Patient, Parent or Guardian　　Relationship to Patient　　Date

WAIVER FOR NO REFERRAL (if applicable)

Your current insurance requires a referral from your Primary Care Physician before our physicians can see you and before we can submit a bill to your insurance company for reimbursement. Since you do not have a referral, we require that you pay $75 up front and establish a payment agreement for the balance. If a referral is obtained at a later date or a referral is not necessary and the insurance company's Explanation of Benefits has shown the service to be eligible for payment, you will be reimbursed any overpaid amounts.

I have elected to visit this specialist and to receive services without a written insurance referral from my primary care physician.

Signature of Patient, Parent or Guardian　　Relationship to Patient　　Date

Patient Name: ______________________ Date of Birth: ______________________

Past Medical History:

Do you or have you ever had any of the following medical conditions:

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune disorder
- ☐ Bleeding disorder
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Chronic Pain
- ☐ COPD
- ☐ Diabetes
- ☐ Depression/Anxiety
- ☐ Emphysema
- ☐ Eye problems
- ☐ Hearing Aids
- ☐ Hearing Problems
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ History of Heart Attack
- ☐ HIV
- ☐ Innocent Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Kidney Disease
- ☐ Liver Disease, Hepatitis
- ☐ Lung Disease
- ☐ Migraines
- ☐ Muscle Disorder
- ☐ Neurological Problems
- ☐ Do you require antibiotics prior to dental or other procedures
- ☐ Other medical conditions that require medications: ______________________
- ☐ Prostate Problems (male)
- ☐ Reproductive Problems
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Stent Placement
- ☐ Stroke
- ☐ Thyroid Disorder

In addition to the questions above, for Pediatric Patients:

- ☐ Premature Birth Delivery at ________ weeks
- ☐ Asthma, reactive airway disease, wheezing, or any use of nebulizer at home

Surgical History:

Have you ever had surgery or received anesthesia for any procedure? ______________________

If yes, please list the type of surgery/procedure and the year performed:

____

Do you or any of your direct family members have a history of Malignant Hyperthermia or other adverse reaction to anesthesia?

☐ Yes ☐ No ☐ Unknown

Current Medication:

List all medications taken regularly with dosage instructions (include prescription AND over the counter medications, vitamins, supplements):

____

____

Allergies:

List any medication, food, Latex or environmental allergies along with their reaction:

____

Family History:

Have any of your immediate family members had any of the following conditions:

Condition	Relationship	Condition	Relationship
☐ Cancer		☐ Diabetes	
☐ Hearing Loss		☐ Heart Disease	
☐ Thyroid Disease		☐ Brain Tumor	
☐ Bleeding Disorders		☐ Anesthesia Problems	

Social History:

Do you smoke or have you ever? __________ If so, how much a day?__________ how much a week?________

How old were you when you started smoking?__________How old were you when you quit smoking?__________

Do you drink alcohol? __________ If yes, how many drinks per day? __________ Per week? __________

Do you or have you ever had any dependency to drugs? __________ If so, to what drug(s)? __________

For Pediatric Patients:

Does anyone in the house smoke? ______________ Does child attend daycare?______________

Vaccinations:

Have you had a Flu Vaccine? __________ Have you had a Pneumonia Vaccine?__________

Other:

Do you have a Healthcare Proxy or Advanced Directive? __________